Indiana State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 002674 | A. BUILDING _____ B. WING _____ | 06/16/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BLOOMINGTON ENDOSCOPY CENTER LLC | 550 LANDMARK AVE BLOOMINGTON, IN 47402 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>This visit was for a licensure survey.<br><br>Date of survey: 06/15-16/11<br><br>Facility number: 002674<br><br>Surveyor: Jennifer Hembree, R.N.<br>Public Health Nurse Surveyor<br><br>Bloomington Endoscopy Center LLC is in compliance with 410 IAC 15-2, Ambulatory Surgery Center Licensure Rules.<br><br>QA: claughlin 06/20/11 | S 000 | | |

Indiana State Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE